Please circle the reason:

- ❖ Location
- ❖ Customer Service
- ❖ Personal Preference
- ❖ Another known Provider
- ❖ Other_____

MY HEALTH GPS

OPT OUT FORM

TO BE COMPLETED BY/FOR *MY HEALTH GPS* BENEFICIARIES

This form must be completed when a beneficiary has not enrolled in the Program and decides not to participate in the Program. Please submit by secure email to myhgps@dc.gov or return to DHCF by mail: 441 4th St, NW, Suite 900 South, Washington, DC 20001.

Date _____

Name of Beneficiary:	Medicaid #
Current *My Health GPS* Program:	MCO if applicable

Beneficiary initials *or* Staff to initials, if the consultation is done by phone, to signify the information has been discussed

When you do not want to participate in the *My Health GPS* program, you need to know that:	
	I have received information about the My Health GPS Program
	I have the right to opt- out without any interruptions of my other services
	I understand I can change my mind and enroll at any time, as long as, I remain eligible for the program
	I know to call this My Health Provider or DHCF if I want or need additional information about the program

Beneficiary or Legal Guardian Name (Please Print) _____

If Legal Guardian's Signature, print name _____

Date Signed _____

☐ I discussed the *My Health GPS* program with the Beneficiary. The benefits were explained; however, he/she decided not to participate in My Health GPS. **In- person** ☐ **Via telephone** ☐

Signature of the *My Health GPS* Staff: _____

Name of *My Health GPS* Care Provider: _____

Date Signed _____
(Attributed Provider Notification date)

----------FOR DHCF USE ONLY----------

Date Form Received:	Date Opt-Out effective:	Date Beneficiary letter mailed:

v2 April 1, 2019